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Manchester Health Department  
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**MANCHESTER HEALTH & SCHOOL DEPARTMENT  
MEDICATION OR PROCEDURE PERMISSION AND PHYSICIAN ORDER FORM**

STUDENT: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

MEDICATION/PROCEDURE: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ ROUTE: \_\_\_\_\_

TIME OF ADMINISTRATION: \_\_\_\_\_

SPECIAL INSTRUCTIONS (Optional): \_\_\_\_\_

PRESCRIBED BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Signature of Health Care Provider)

**PARENT PERMISSION**

I hereby authorize the designated staff person to administer the above prescribed medication procedure according to the directions. In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, the City of Manchester and/or any department or employee thereof for any death or injury resulting from the administration or assistance in the administration of the medication described above.

Signature of parent / guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Field Trip:**

Option: I ☐ **do** ☐ **do not** wish to have my child's medication administered by designated  
(initials in box please) staff person on a fieldtrip. ☐ Initials in box

**(Optional Release - Signature Required)**

I hereby authorize that, if necessary the school nurse and above physician may share information relative to the health of my child (name) \_\_\_\_\_.

Parent /Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_